ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
   - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. Document details. This medication should be reviewed for need at each request for reauthorization.

See following pages for specific drug lists.

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers **(continued page 2)**

ACE Inhibitors and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Benazepril	Accupril®
Benazepril/HCTZ	Accuretic®
Captopril	Aceon®
Captopril/HCTZ	Altace®
Enalapril	Capoten®
Enalapril/HCTZ	Capozide®
Lisinopril	Fosinopril
Lisinopril/HCTZ	Fosinopril/HCTZ
	Lotensin®
	Lotensin HCT®
	Mavik®
	Moexipril
	Monopril®
	Monopril HCT®
	Quinapril
	Quinaretic
	Prinivil®
	Prinzide®
	Uniretic®
	Univasc®
	Vaseretic®
	Vasotec®
	Zestoretic®
	Zestril®

ACE Inhibitor plus Calcium Channel Blocker Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Lotrel®	Lexxel®
	Tarka®
	Teczem®

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers **(continued page 3)**

ACE Inhibitors and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Cozaar®	Atacand®
Diovan®	Atacand HCT®
Diovan HCT®	Avalide®
Hyzaar®	Avapro®
	Benicar®
	Benicar HCT®
	Micardis®
	Micardis HCT®
	Teveten®
	Teveten HCT®

Beta Blockers and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Acebutalol	Betapace®
Atenolol	Betapace AF®
Atenolol/Chlorthalidone	Blockadren®
Betaxolol	Cartrol®
Bisoprolol Fumarate	Corgard®
Bisoprolol/HCTZ	Corzide®
Coreg®	Inderal®
Labetalol	Inderal LA®
Metoprolol/HCTZ	Inderide®
Metoprolol tartrate	Innopran XL®
Nadolol	Kerlone®
Pindolol	Levatol®
Propranolol	Lopressor®
Propranolol/HCTZ	Lopressor HCT®
Sorine®	Normodyne®
Sotalol	Sectral®
Sotalol AF	Tenoretic®
Timolol Maleate	Tenormin®
	Timolide®
	Toprol XL®
	Trandate®
	Zebeta®
	Ziac®

TOPROL XL®: Authorize if any of the following are true
• Toprol XL® 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID. Toprol XL® 25mg will be authorized with a quantity limit of 45 tablets per 30 days.
Doses >37.5 mg Toprol XL® po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID
• If patient compliance is questioned or compromised by change, then the Toprol XL® will be authorized

Antibiotics: Cephalosporins, Macrolides, Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

Cephalosporins

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Second Generation Cephalosporins	
Cefaclor	Ceclor®
Cefaclor suspension	Ceclor® CD
Cefaclor ER	Ceftin® tablets
Ceftin® suspension	Cefprozil
Cefuroxime tablets	
Cefzil®	
Cefzil® Suspension	
Lorabid®	
Lorabid® Suspension	
Raniclor®	
Third Generation Cephalosporins	
Cedax®	Cefpodoxime
Cedax® Suspension	Suprax Susp®
Omnicef®	Vantin®
Omnicef® Suspension	Vantin Susp®
Spectracef®	

Antibiotics – Cephalosporins, Macrolides, Quinolones *(page 2)*

Macrolides

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Macrolides	
Biaxin®	Azithromycin
Biaxin® Suspension	Clarithromycin
Biaxin XL®	Dynabac®
Erythrocin stearate	E.E.S.®
Erythromycin base	ERYC®
Erythromycin ethylsuccinate	Eryped®
Erythromycin estolate suspension	Ery-tab®
Erythromycin stearate	Ketek®
Erythromycin with sulfisoxazole	PCE®
Zithromax®	ZMAX® suspension
Zithromax® Suspension	

Quinolones

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Second Generation Quinolones	
Ciprofloxacin	Cipro®
Ciprofloxacin Suspension	Cipro® Suspension
Ciprofloxacin XR	Cipro XR®
Ofloxacin	Floxin®
	Maxaquin®
	Noroxin®
Third Generation Quinolones	
Avelox®	Factive®
Avelox ABC PACK®	Levaquin®
	Tequin®
	Zagam®

Antifungals (Oral) for Onychomycosis

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

2. If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

Sporanox

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

Transfer requests for any other diagnosis to a clinical pharmacist.

ORAL ANTIFUNGALS USED FOR ONYCHOMYCOSIS

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Lamisil®	Itraconazole Sporanox®

Low Sedating Antihistamines: Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with one product not requiring prior approval, then may approve the requested medication.
   Document details

Second Generation Antihistamines and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Alavert®	Allegra®
Alavert-D®	Allegra-D®
Claritin OTC®	Clarinex®
Claritin OTC® Syrup	Clarinex-D®
Claritin-D OTC®	Claritin® Rx forms
Loratadine	Claritin-D® Rx forms
Loratadine/PSE	Fexofenadine
	Fexofenadine/PSE
	Zyrtec®
	Zyrtec® syrup no PA required < 2yrs of age
	Zyrtec-D®

Antimigraine Medications: Serotonin Receptor Agonists "Triptans"

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be switched to a non-prior approved medication? Acceptable reasons include:
   - Allergy to **one** of the non-prior approved products
   - Contraindication to all non-prior approved product(s)
   - History of unacceptable side effects to **one** of the non-prior approved product(s)

   Document clinically compelling information

2. Has the patient had therapeutic trial of **one** non-prior authorized drug that failed? If so, document and allow the prior authorized medication.

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

Triptans

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Imitrex® all forms - tabs, spray, injectable	Amerge®
Maxalt®	Axert®
Maxalt MLT®	Frova®
	Relpax®
	Zomig® tabs, nasal spray
	Zomig ZMT®

Antivirals: Herpes

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Herpes

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Acyclovir Tablets	Zovirax Tablet ®
Acyclovir Susp	Zovirax Susp®
Famvir ®	
Valtrex ®	

Antivirals: Influenza

LENGTH OF AUTHORIZATIONS:

- For diagnosis of influenza the authorization is for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Influenza

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Amantadine	Flumadine®
Amantadine Syrup	Flumadine Syrup®
Relenza Disk®	Symmetrel
Rimantadine	Symmetrel Susp
Tamiflu®	
Tamiflu Susp®	

Beta-Adrenergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **two-week** trial of at least **one** medication not requiring prior approval **within the same class and formulation**. (ie nebulizers for nebulizers)
   Document details

ADDITIONAL INFORMATION

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

Beta Adrenergic Agents

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Short Acting and Combination Metered Dose Inhalers or Devices	
Albuterol	Proventil®
Alupent MDI	Ventolin®
Combivent® MDI	Albuterol HFA
Maxair Autohaler®	
Proventil HFA®	
Ventolin HFA®	
Xopenex® HFA	
Long Acting Metered Dose Inhalers	
Foradil®	
Serevent Diskus®	
Short Acting Nebulizers	
Accuneb® *pediatric dosing, premixed nebs*	Proventil®
Albuterol Sulfate *premix & concentrate*	
Metaproterenol	
Xopenex®	

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
    - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
    - The requested medications corresponding generic (if a generic is available and covered by the state) has been attempted and failed or is contraindicated

CLINICAL NOTES

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

Vascor is in its own third class of Calcium Channel Blockers and not included under PA requirements on the VA PDL at this time.

See next page for specific drug lists.

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers
(continued)

Calcium Channel Blockers

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Dihydropyridine Calcium Channel Blockers	
Afeditab CR®	Adalat CC®
Dynacirc®	Cardene®
Dynacirc CR®	Cardene SR®
Nicardipine	Felodipine
Nifediac CC®	Procardia®
Nifedical XL®	Procardia XL®
Nifedipine	
Nifedipine ER	
Nifedipine SA	
Norvasc®	
Plendil®	
Sular®	
Non-Dihydropyridine Calcium Channel Blockers	
Cartia XT®	Calan®
Diltia XT®	Calan SR®
Diltiazem	Cardizem®
Diltiazem SR q 12hr dose	Cardizem CD®
Diltiazem ER q 24hr dose	Cardizem LA®
Taztia XT®	Cardizem SR®
Verapamil	Covera HS®
Verapamil SA	Dilacor XR®
Verapamil 24hr pellets	Isoptin SR®
	Tiazac®
	Verelan®
	Verelan PM®

Central Nervous System Stimulants/ADHD Medications

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details.

3. The patient must have failed the generic product (if covered by the State) before the brand is authorized.

4. If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Amphetamine Products	
Adderall XR®	Adderall®
Amphetamine Salts combo	Desoxyn®
Dextroamphetamine	Dexedrine®
Dextroamphetamine SR	Dexedrine spansule®
Dextrostat®	
Methylphenidate Products	
Concerta®	Ritalin®
Focalin®	Ritalin SR®
Focalin XR®	
Metadate CD®	
Metadate ER®	
Methylin®	
Methylin ER®	
Methylphenidate	
Methylphenidate SR	
Ritalin LA®	
Miscellaneous Products	
Strattera®	Provigil®

Corticosteroids: Inhaled and Nasal Steroids

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.
   Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, and then may approve the requested medication.
   Document details

2. If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.
   Document details

See next page for specific drug lists.

Corticosteroids: Inhaled and Nasal Steroids (continued page 2)

Inhaled Corticosteroids

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Metered Dose Inhalers	
Aerobid® Aerobid M® Asmanex® Azmacort® Flovent HFA® QVAR®	Flovent Rotadisk® Pulmicort Turbohaler® Flovent®
Nebulizer Solution	
Pulmicort Respules®	
Combination Products (Glucocorticoid and Beta Adrenergic)	
Advair Diskus	

Nasal Steroids

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Flonase® Flunisolide Nasacort AQ® Nasonex®	Beconase AQ® Fluticasone Nasacort® Nasarel® Rhinocort AQUA® Tri-Nasal®

COPD: Anticholinergics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication. Document details

COPD Anticholinergics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Atrovent®	
Atrovent HFA®	
Combivent®	
Duoneb®	
Spiriva®	

COX-2 Inhibitors

Clinical edit

LENGTH OF AUTHORIZATIONS: 1 year

The preferred product may be approved for patients if one of the following is true:

- If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs
- Concurrent use of anticoagulants (warfarin or heparin)
- Chronic use of oral corticosteroids
- Concurrent use of methotrexate
- History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
- If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer caller to a clinical pharmacist
- Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex®) may be approved without any risk factors or trials on NSAIDs.

CRITICAL INFORMATION TO CONSIDER

1. Selective cyclooxygenase-2 (COX-2) inhibitors are known to inhibit the production of vascular prostacyclin (PGI2), an inhibitor of platelet aggregation and a vasodilator. Unlike conventional non-steroidal anti-inflammatory drugs, COX-2 inhibitors do not reduce the endogenous production of thromboxane A2, a potent platelet activator and aggregator, thereby causing a potentially prothrombotic cascade of events that could lead to a significant increase in the risk for thrombotic cardiovascular events (myocardial infarction, occlusive stroke) in patients receiving celecoxib therapy. **Therefore, it is advisable to exercise caution when prescribing celecoxib, a COX-II inhibitors to patients with a higher risk of cardiovascular disease.**

2. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.

3. If allergic to sulfonamides, a patient should not receive Celebrex®.

Cox-2 Inhibitors

Preferred Drugs - PA Required	Non-preferred Drugs - N/A
Celebrex®	

Electrolyte Depleters

LENGTH OF AUTHORIZATIONS: 1 year

2. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Electrolyte Depleters

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Fosrenol® Phoslo® Renagel®	

Gastrointestinals: Histamine -2 Receptor Antagonists (H-2 RA)

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details

3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, and then may approve the requested medication.

H2 Receptor Antagonists

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Famotidine	Axid®
Ranitidine	Cimetidine
	Nizatidine
	Pepcid®
	Tagamet®
	Zantac®
	Zantac® syrup *no PA required for age < 12yrs*

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   Allergy to medications not requiring prior approval
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.
   Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** with Protonix, then may approve the requested medication.
   Document details

3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, and then may approve the requested medication.

Gastrointestinals: PPIs

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Protonix®	Aciphex®
Prilosec OTC®	Nexium®
	Omeprazole *no PA req age < 12yrs*
	Prevacid® caps *no PA req age < 12yrs*
	Prevacid® susp *no PA req age < 12yrs*
	Prevacid® solutab
	Prilosec® Rx form
	Zegerid® susp

SPECIAL CONSIDERATION:

Protonix® is a delayed release tablet and cannot be crushed or opened. For tubed patients or patients with swallowing difficulties omeprazole, Prevacid®, Prevacid Solutab®, Prilosec®, Nexium or Prevacid® granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved. If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved.
Aciphex® is an extended release tablet and should not be opened or crushed.

Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
     Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval

3. The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

Glaucoma Agents

Beta Blockers	
Betaxolol 0.5% drops	Betagan® 0.25% & 0.5% drops
Betimol® 0.25% &0.5% drops	Istalol® 0.5% drops
Betoptic-S® 0.25% susp drops	Ocupress® 1% drops
Carteolol 1% drops	Optipranolol 0.3% drops
Levobunolol 0.25% & 0.5% drops	Timoptic® drops 0.25% & 0.5% drops
Metipranolol 0.3% drops	Timoptic XE® 0.25% & 0.5% Sol-Gel
Timolol maleate drops 0.25% &0.5% drops	
Timolol maleate 0.5 % Sol-gel	
Carbonic Anhydrase Inhibitors	
Azopt® 1% drops	
Cosopt® 0.5%-2% drops	
Trusopt® 2% drops	
Prostaglandin Analogs	
Lumigan® 0.03% drops	Rescula® 0.15% drops
Travatan® 0.0004% drops	
Xalatan® 0.005% drops	

Immunomodulators: Topical

LENGTH OF AUTHORIZATION: **1 YEAR**

CLINICAL CONSIDERATIONS:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least two medications** not requiring prior approval, then may approve the requested medication.

Critical information for review:

FDA ALERT [03/2005] – The FDA has issued a public health advisory to inform healthcare professionals and patients about a potential cancer risk from use of Protopic (tacrolimus) AND Elidel (pimecrolimus). This concern is based on information from animal studies, case reports in a small number of patients, and knowledge of how drugs in this class work. It may take human studies of ten years or longer to determine if uses of Protopic OR Elidel are linked to cancer. In the meantime, this risk is uncertain, and FDA advises Protopic and Elidel should be used only for patients after other prescription treatments have failed to work or cannot be tolerated.

This information reflects FDA's preliminary analysis of data concerning this drug. FDA is considering, but has not reached a final conclusion about, this information. FDA intends to update this sheet when additional information or analyses become available.

FDA Recommendations:

Physicians with patients using Elidel, or who are considering prescribing the drug, should consider the following:

- Use Elidel or Protopic only as **second-line** agents for short-term and intermittent treatment of atopic dermatitis, a form of eczema, in patients unresponsive to, or intolerant of other treatments.
- Avoid use of Elidel or Protopic in children younger than 2 years of age. The effect of Elidel on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than those treated with placebo cream.
- Use Elidel or Protopic only for short periods of time, not continuously. The long term safety of Elidel is unknown.

Immunomodulators: Topical (continued page 2)

- Children and adults with a weakened or compromised immune system should not use Elidel or Protopic.
- Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

Topical Immunomodulators

Preferred Drugs - PA Required	Preferred Drugs - PA Required
Elidel® Protopic®	

Leukotriene Receptor Antagonists

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.
   Document details

Leukotriene Receptor Antagonists

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Accolate® Singulair®	Zyflo®

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

General Guidelines:

Currently there are four classes of medications in the Lipotropics with three classes represented in the PDL. Each class has a different mechanism of action and acts on different components of total cholesterol

- Fibric acid derivatives- (New to PDL as of P&T June 05)
- HMG COA reductase Inhibitors –Already PDL
- Nicotinic acid derivatives- (New to PDL as of P&T June 05)
- Bile Acid Resins *(not included in VA PDL at this time)*

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details

See next pages for specific drug lists.

Lipotropics (continued page 2)

Lipotropics – Fibric Acid Derivatives

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Antara® Gemfibrozil	Lofibra® Lopid® Tricor® Triglide®

Lipotropics – Niacin Derivatives

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Niacor® Niaspan®	

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (Statins)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Advicor® Altoprev® Lescol® Lescol XL® Lovastatin Pravachol® Zocor®	Caduet® Crestor® Lipitor® Mevacor® Pravastatin Vytorin®

Lipotropics - CAI

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Zetia®	

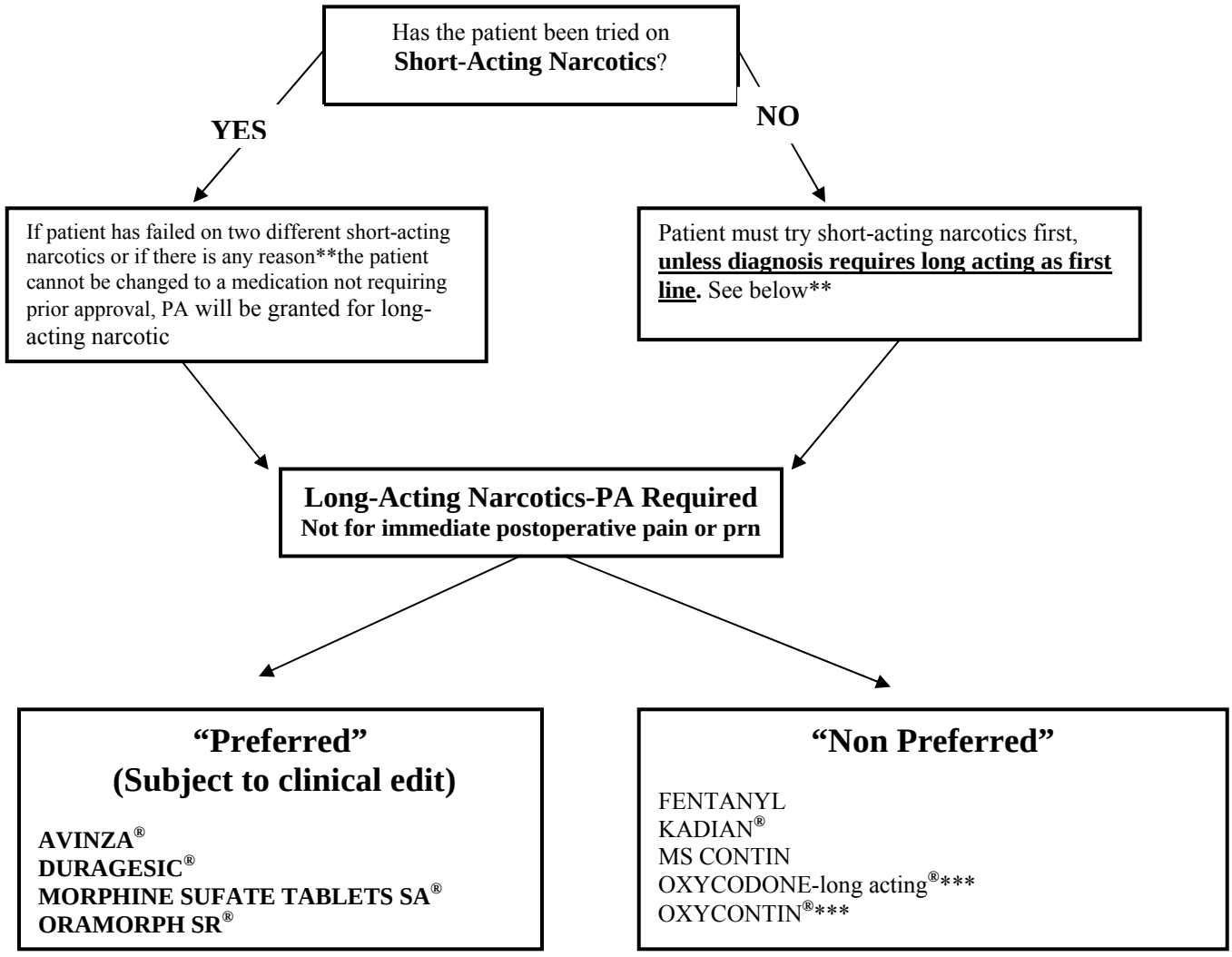
Long Acting Narcotics – Step Therapy

SHORT ACTING NARCOTICS (no PA required)

Butalbital Combinations
Butalbital w/codeine
Codeine
Codeine w/APAP
Codeine w/ASA
Hydrocodone
Hydrocodone w/APAP
Hydromorphone
Levorphanol
Meperidine
Methadone*
Morphine-short acting
Nalbuphine
Oxycodone-short acting
Oxycodone w/APAP
Oxycodone w/ASA
Oxymorphone
Pentazocine combinations
Propoxyphene combinations

**The use of methadone for pain should ideally be done in the context of an organized pain clinic, hospice or with assistance of local pain management experts, including health care providers or pharmacists, who have experience with methadone use.*

Step-Therapy



****Step-Therapy is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time.** Additional acceptable reasons include:

- Allergy to medications not requiring prior approvals
- Contraindications to or drug-to-drug interaction with medications not requiring prior approval
- *If the patient has a diagnosis that is an approved indication for the medication that requires prior approval and this diagnosis is not an indication for the medications that do not require prior approval.*
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

LENGTH OF AUTHORIZATIONS: 6 months

OxyContin* / Oxycodone-long acting***Guidelines**

1. Coverage is limited to those persons 18 years of age or older with a need for a continuous around-the-clock analgesic for an extended period of time for the management of moderate to severe pain.

2. There are no diagnosis restrictions here. The main objective is to verify appropriate use and the following items should be taken into consideration when reviewing an oxycontin request:

- Dosing frequency greater than bid (tid for an identified, organized pain clinic or pain specialist)
- Dosing using multiple small strength tablets as opposed to a single higher strength tablets
- Odd quantities that would result in fractional dosing
- Patient history of substance abuse
- Frequent early refill attempts
- Multiple request pertaining to lost medication
- Short-term or prn use (oxycontin is not indicated for short-term or prn use)
- Any suspicious use reported by pharmacies or physicians
- A rapid increase in dosage
- 80mg tablets are for opioid tolerant patients only

3. Reasons for denial:
- Split tablets
- Greater than tid dosing frequency
- Concurrent use of other extended release opioids
- Prn dosing

1997 medical society of Virginia and house of delegates guidelines Virginia code 54.1-2971.01 states:

"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this section."

NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

LENGTH OF AUTHORIZATIONS: 1 YEAR

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. The requested medication may be approved if **both** of the following are true:
   - If there has been a therapeutic failure to no less than a **one-month** trial of at least **two** medication(s) within the same class not requiring prior approval
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to a clinical pharmacist.

ADDITIONAL INFORMATION TO CONSIDER

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.

NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

(page 2)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Diclofenac potassium	Anaprox®
Diclofenac sodium	Anaprox DS®
Diflunisal	Ansaid®
Etodolac	Arthrotec®
Etodolac SR	Cataflam®
Fenoprofen	Clinoril®
Flurbiprofen	Daypro®
Ibuprofen	Dolobid®
Indomethacin	Feldene®
Indomethacin SR	Indocin®
Ketoprofen	Indocin SR®
Ketoprofen ER	Lodine®
Ketorolac	Lodine XL®
Meclofenamate sodium	Mobic®
Nabumetone	Motrin®
Naproxen	Nalfon®
Naproxen sodium	Naprelan®
Oxaprozin	Prevacid Naprapac®
Piroxicam	Naprosyn®
Sulindac	Orudis®
Tolmetin Sodium	Oruvail®
	Ponstel®
	Relafen®
	Tolectin DS®
	Toradol®
	Voltaren®
	Voltaren XR®

Ophthalmic Antihistamines/Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Antihistamines

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Elestat drops® Optivar drops® Patanol drops® Zaditor drops®	Emadine drops®

Ophthalmic Mast Cell Stabilizers

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Alamast drops® Alocril drops® Alomide drops® Cromolyn Sodium	Crolom drops®

Ophthalmic Anti-inflammatory

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:
- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a 3 **day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Anti-Inflammatory

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Acular drops®	Acular PF droperette®
Acular LS drops®	Ocufen drops®
Flurbiprofen Sodium	
Nevanac drops Susp®	
Voltaren drops®	
Xibrom drops®	

Ophthalmic Fluoroquinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:
- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Fluoroquinolones

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Ciprofloxacin drops	Ciloxan drops®
Ofloxacin drops	Ciloxan oint®
Quixin drops® Vigamox drops® Zymar drops®	Ocuflox drops®

Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 YEAR

1. Is there any reason the patient cannot be switched to a non-prior approved medication?
Acceptable reasons include:
   - Allergy to the non-prior approved products in this class
   - Contraindication or drug to drug interaction with all non-prior approved products
   - History of unacceptable side effects

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial of thirty days with **one** of the non-preferred drugs **within the same class**? If so, document and approve the prior authorized drugs.

Oral Hypoglycemics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Alpha-Glucosidase Inhibitors	
Glyset® Precose®	
Biguanides	
Metformin Metformin ER	Glucophage® Glucophage XR® Fortamet® Riomet® suspension
Biguanide Combination Products	
Avandamet® Glipizide/metformin Glyburide/metformin	Glucovance® Metaglip®
Meglitinides	
Starlix®	Prandin®
Thiazolidinediones	
Actos® Avandia® Actoplus Met®	Avandryl®
Second Generation Sulfonylureas	
Glipizide Glipizide ER Glyburide Glyburide micronized Glimepiride	Amaryl® Diabeta® Glucotrol® Glucotrol XL® Glynase® Micronase®

Osteoporosis Agents – Bisphosphonates

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medication not requiring prior approval
- Contraindication to or drug-to-drug interaction with medication not requiring prior approval
- History of unacceptable/toxic side effects to medication not requiring prior approval

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a preferred drug **within the same class**? If so, document and approve the prior authorized drug.

Bisphosphonates

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Actonel® Fosamax® Fosamax® solution Fosamax plus D®	Actonel with calcium® Boniva®

Phosphodiesterase 5 Inhibitors
Pulmonary Arterial Hypertension

LENGTH OF AUTHORIZATIONS: 1 year

Diagnosis of Pulmonary Hypertension in patients 18 years of age or older is required.

The requested medication may be approved if both of the following are true:

- The prescribing physician is a pulmonary specialist or cardiologist.
- Client has documented Pulmonary Arterial Hypertension and will be followed by the prescribing physician.

Document clinically supporting information

Contraindications where the PA should not be approved:

- Concurrent use of nitrates (e.g., nitroglycerin)
- Hypersensitivity to Sildenafil.

PD5 Inhibitor

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Revatio 20mg	

Sedative/ Hypnotics

LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month** trial of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details

3. If a request for Ambien® is received for a pregnant patient, approve the Ambien® for the duration of the prescription or the duration of the pregnancy (whichever is shorter).

4. For **patients age 65 and older**, Ambien or Lunesta® may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patient's ≥ 65 to try a benzodiazepine if they have had a trial of trazodone.

Sedative Hypnotics (Benzodiazepine)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Estazolam Flurazepam Restoril® **7.5mg** *until generic available* Temazepam Triazolam Chloral hydrate	Dalmane® Doral® Halcion® Prosom® Restoril®

Sedative Hypnotics (Non-Benzodiazepine)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
	Ambien® Ambien CR® Lunesta® Rozerem® Somnote® Sonata®

Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Urinary Antispasmodics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Ditropan XL® Detrol LA® Enablex® Oxybutynin Oxytrol® transdermal Sanctura® Vesicare®	Detrol® Ditropan®